MONTANA
TELECOMMUNICATIONS
ASSOCIATION

November 5, 2012

Ms. Marlene Dortch, Secretary
Federal Communications Commission
445 12th Street, SW
Washington, D.C. 20554

RE:
Call Termination: *Establishing Just and Reasonable Rates for Local Exchange Carriers,* WC Docket No. 07-135; *Developing a Unified Intercarrier Compensation Regime*, CC Dkt No. 01-92; *Rules and Regulations Implementing the Truth in Caller ID Act of 2009*, WC Dkt No. 11-39
Lifeline Program: *Lifeline and Link Up Reform and Modernization* et al., WC Docket Nos. 11-42, 03-109, 12-23 and CC Docket No. 96-45
Rural Health Care Program: *Rural Health Care Support Mechanism*, WC Docket No. 02-60
Contributions Reform: *Universal Service Contribution Methodology*, WC Docket No. 06-122

Dear Ms. Dortch,

The undersigned, representing the Montana Telecommunications Association (MTA), met on October 31, 2012, with Trent Harkrader, Division Chief, and Linda Oliver of the Telecommunications Access Policy Division to discuss rural health care reform, lifeline reform and contributions reform. Also on October 31, the undersigned met with Margaret Dailey and staff of the Enforcement Bureau to discuss call termination problems. MTA also met with legal advisors to Commissioners Clyburn (Angie Kronenberg), Pai (Nick Degani), McDowell (Christine Kurth) and Rosenworcel (Priscilla Argeris) on October 31 and November 1 to discuss all of these issues. A more detailed description of these discussions follows.

Call Termination

The problem persists despite the Commission's *Declaratory Ruling* issued earlier this year. Consumers continue not to receive calls from family and business associates, or example, thus causing personal disruption and loss of business opportunities and jobs in rural America. The issue has persisted so long that consumers and telecom providers alike are losing hope that anything will be done to end this scourge. Meanwhile, attention continues to be focused—wrongly—on terminating carriers rather than on originating and middle networks.

Anecdotally, the issue is illustrated by a hospital in Vermont where hospital staff reportedly informs patients calling in from a nearby rural exchange to call the hospital back if the patients don't receive return calls promptly from hospital staff. In other words, staff has gotten accustomed to calls failing to complete to the rural exchange and has adopted an unofficial practice of asking residents in the rural exchange to call the hospital because calls coming into the urban area are more likely to terminate.

MTA urged the Enforcement Bureau to proceed immediately with investigation *and enforcement action* against originating and/or middle-network carriers responsible for failing to ensure that calls terminate properly on terminating networks.

Lifeline

The Lifeline Program continues to grow out of control. It is the only program without a "budget," and it shows. Lifeline support is increasing at a rate of between 2% and 5% per month, totaling between $500 million and more than $700 million in 4Q12, or between $2 billion and nearly $3 billion per year, exceeding the size of the Schools and Libraries Program (which is capped at $2.25 billion, plus inflation). USAC estimates that the participation rate (number of eligible Lifeline consumers receiving Lifeline support vs. total population of eligible consumers) is less than 50%, meaning that the Lifeline Program potentially could exceed $5 billion. Reforms adopted by the Commission this year may have a mitigating effect on Lifeline Program growth, but the program continues to grow steadily and rapidly. There are now nearly 700 Lifeline-only CETCs providing Lifeline service across the nation, and more are queued up in the pipeline awaiting Commission approval. It is obvious that the Lifeline Support program is attracting Lifeline providers. The Program may also be providing a windfall to providers that have made business plans based entirely on receiving Lifeline support.

This unrestrained growth is already shining a negative spotlight on the entire Universal Service Fund, despite the fact that all other universal service programs effectively are capped. Continued growth and negative attention threaten the integrity and sustainability of the entire universal service system threatening not only the Lifeline Program, but Schools & Libraries, Rural Health Care and High Cost Programs.

MTA asserts that the current Lifeline support mechanism is similar to the High Cost identical support mechanism that the Commission eliminated in the Universal Service/Intercarrier Compensation *Transformation Order (* FCC 11-161), since the level of support provided to Lifeline-only ETCs has nothing to do with the cost of providing such service.

The Commission should take steps to constrain the uncontrolled growth of the Lifeline Program. The Lifeline Program can continue to deliver services to eligible low-income consumers while restraining growth in Lifeline support by eliminating the Lifeline identical support mechanism. The Commission can accomplish this by setting a default support level that is substantially less than today's $9.25 per eligible Lifeline consumer—an amount that obviously provides enough support to Lifeline ETCs to warrant the continued growth in Lifeline ETC applications. If carriers object to the default support level, they may submit data to the Commission to justify a higher level. Alternatively, the Commission could cap total Lifeline Support at today's level (roughly $2.2 billion) and adjust the Lifeline support amount quarterly to maintain the program at a total amount of $2.2 billion.

Rural Health Care

MTA reiterated its opposition to using rural health care funds to support infrastructure construction. As the American Telemedicine Association (ATA) repeatedly has asserted, such infrastructure funding is "ill-advised." MTA supports ATA's recommendation to re-target the proposed infrastructure support to reforms proposed under the rural health care services program and thereby avoid duplicating other federal programs, including the universal service High Cost Program.

It is important to note that despite unsubstantiated assertions by rural health care infrastructure pilot projects, USAC has not performed a single audit of a pilot program project. Thus, we have no independent validation or verification of assertions made by any rural health care pilot projects. We don't know, for example, how—or whether—pilot projects have met their 15% matching funds requirement. Nor do we know how, or how much "excess capacity" has been sold, or how "fair share" contributions have been funded. (MTA continues to assert that the sale of excess capacity specifically is prohibited by the Telecommunications Act.) Nor has there been any independent validation of any needs assessments—to the extent any needs assessments were performed.

Further, the pilot program lacks performance measurements, one of several deficiencies identified by GAO. (GAO 11-27. 11/17/10.) The lack of attention given to needs, goals, and measurements has resulted in mission creep: projects that may have started as initiatives to enhance access to and delivery of telemedicine applications for the improvement of health care delivery in rural America gradually morphed into fiber broadband deployment projects, which further morphed into public policy initiatives aimed at providing universal service-funded competitive telecommunications services. The program, in short, lacks sufficient front-end due diligence and on-gong governance and oversight.

Existing rural health care infrastructure projects have failed to conduct sufficient needs assessments prior to application for support; avoided sufficient public notice, due diligence and public scrutiny;[1] failed to leverage existing network facilities in lieu of building new facilities, and have not sufficiently limited infrastructure construction to *demonstrated* last-resort situations where all alternatives have been exhausted. The lessons learned from the rural health care infrastructure pilot program demonstrate that infrastructure funding has wasted universal service health care support and has failed to account for long term costs as well as indirect costs associated with removal of anchor institutions from public networks.

It is dubious public policy, at best, to put the Federal Communications Commission in the position of venture capitalist risking valuable universal service health care support for purposes of building duplicative infrastructure by health care providers whose core competencies do not include building, owning and operating sophisticated telecommunications networks in a dynamic, competitive market.

Contributions Reform

MTA urges the Commission to include text messaging as assessable telecommunications in the contributions base. Consumers use text messaging as a functional equivalent to voice communications. For example, consumers regularly text "911" in emergencies. Some telecommunications providers already assess universal service contributions on text messages and the Commission treats text messaging as telecommunications under the Telecommunications Consumer Privacy Act.

MTA also believes it is premature to remove from the "menu" of contributions reform options assessment of broadband connections and services.

Respectfully submitted,

/s/

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[1] The National Broadband Plan recommends a 12-month public notice period prior to any award of rural health care infrastructure support.